EXHIBIT "K"

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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BENITO RODRIGO FAJARDO TARQUI and
LUIS A. FARJARDO, as Administrators of the
Estate of MARIA T. QUIRIDUMBAY, Deceased,

Plaintiffs,

-against-

UNITED STATES OF AMERICA,

Defendant.

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Affirmation

IRA MEHLMAN, MD, a Doctor of Medicine duly licensed to practice in the State of New York, affirms the following under CPLR section 2106:

I affirm that the opinions set forth in my report dated December 9, 2015, are true and correct within a reasonable degree of medical certainty. The contents of the report are incorporated herein by reference.

Dated: New York, New York
October 31, 2016

IRA MEHLMAN, MD

IRA MEHLMAN, MD
420 East 72nd Street Suite 10B
New York City, NY 10021

December 9, 2015

Freidman Sanchez, LLP
Andrew M. Friedman, Esquire
16 Court Street. 26th Floor
Brooklyn, New York 11241

RE: Maria Quiridumbay, deceased
DOB: 08/20/1974
DOD: 07/29/2010

I am a physician duly licensed in New York with over forty-five years clinical practice experience, with greater than 20 years board certification in Emergency Medicine and director of emergency departments, also board certified in Internal Medicine, and a Fellow of both the American College of Emergency Physicians (FACEP) and the American College of Physicians (FACP). I received my bachelor degree in Physics and Molecular Biology at Princeton University and my Medical Degree at Cornell Medical College. I have taught medicine and attained the level of Associate Professor of Medicine. I have directed ambulatory care, urgent care, and walk-in clinics as well as emergency medicine departments during my career.

I am entirely familiar with the accepted standards of medical care in the fields of ambulatory health care center treatment, emergency medicine and gynecologic medicine as it pertains to this case, for the period of time and region applicable in this matter. I have no financial interest in the outcome of any proceedings concerning this case.

The basis for my medical opinions are derived from my education and clinical experience as a physician and director of ambulatory care clinics and emergency departments, and from the review of the following medical records and materials concerning the subject litigation:

(a) Medical Records from Hudson Valley Hospital Center, 2010;
(b) Medical Records from Westchester Medical Center, 2010.
(c) Medical Records from Angel B. Polimeni, MD;
(d) Transcripts of Depositions of Drs. Hyun Chung, MD and Sachin J. Shah, MD.
(e) Transcript of Deposition of Lindsay Seekircher
(f) Transcript of Deposition of Ingrid Deler-Garcia
(g) Transcript of Deposition of Rashmi Kar, MD
(h) Transcript of Deposition of Theresa Ang, RN

In July 2010, Maria Quiridumbay (hereinafter, Maria) was a 35 year old Hispanic female, Spanish speaking, mother of one, pregnant (LMP 10/15/2009), with a previous history of rheumatoid arthritis on prednisone, otherwise healthy.

On Sunday, July 11, 2010, she presented to the Hudson Valley Hospital Center, Cortlandt Manor, NY, at 20:48 pm, with abdominal pain, backpain and contractions, in labor. She was admitted, had epidural anesthesia, iv Pitocin given, and delivered her baby vaginally 07/13/2010, 16:10 pm. The baby was born septic and cared for in the neonatal ICU (NICU) from 7/13/10 until discharge 7/23/10. The infant did well. On 7/14/10, postpartum day # 1, at around 17:05 pm a certified nurse midwife (CNM-Brooks) was called to evaluate Maria because her temperature was 101.9 orally, and the patient felt hot. Earlier on 7/14/10 at around 12:51 am her temperature had been 102.2. The CNM discussed the case with the OB-GYN Dr. Kar. A CBC and one blood culture were obtained as well as urine and vaginal cultures, and she was begun on Ancef and Clindamycin iv. Apparently the WBC was very elevated at 34,000 with 44 Bands on 7/15/10 with blood cultures + for gram + cocci in chains. A report from the lab of "many beta strep group A" was reported to Dr. Kar per progress note of Eileen Rossi, RN, 7/15/2010. Maria was treated for her "non focal postpartum fevers" as presumed postpartum endometritis with four doses of Cefazolin and Clindamycin, iv. Dr. Kar and Sara Jordan MD were apparently the OB doctors involved in her care. On postpartum day # 2 she was sent home without antibiotics, a discharge note was dictated by Sara Jordan, MD. A CBC performed on 7/16/10, was still very abnormal with WBC 23,500 with left shift 94 Neutrophils including 13 Bands. Her hematocrit and hemoglobin were low Hgb 9.1, Hct 26.5. She had apparently received only two days of antibiotics for the "presumed" infection and was discharged without further antibiotic therapy.

On Monday, 7/26/10, Maria had worsening aches and pains particularly in her legs and knees and contacted her OB-GYN doctor Rashmi Kar, MD who advised her to return back to the same Hudson Valley Hospital where she delivered and was discharged 11 days earlier with the above history. Dr. Kar told her to go to the ED and called and spoke with ED attending Hyun Chung, MD recounting her history. Maria returned to the emergency department (ED) with *"left knee pain and swelling. Sudden onset yesterday through the night (denies recent trauma) States she is not able to walk, not able to bear weight."* She came into the ED with a 10/10 throbbing pain at around 15:02. She apparently was seen in the "Fastrack" area of the ED. In the history of present illness (HPI) she noted + swelling and the past medical history (PMH) noted the history of rheumatoid arthritis (RA). The physical exam of Maria noted Temp 98.7 oral, pulse 88, Resp 18 with BP 92/55 and a pulse ox at 100% on room air. The extremity exam showed mild swelling and tenderness. No female pelvic exam was performed despite recent past history. Ancillary testing demonstrated a persistent very elevated WBC count at 21,800 with a persistent "left shift of neutrophils at 91%" (of which 9 were Bands) and knee x rays revealed a "moderately large effusion" in the region of the left supra-patellar area. Lindsay Aarstad, a physician's assistant (PA) primarily "conducted the evaluation, management and treatment" of Maria, as noted on page 3 of her note. Dr. Hyun Chung was the ED physician staffing PA Aarstad, and he apparently had spoken with Maria's gyn doctor, "Dr. Kar prior to patient's arrival in the ED, and she reports the patient was diagnosed with RA during pregnancy". Despite the ED Department Medical Decision Making component of page 3 of the ED chart remarking that *infectious arthritis* should appropriately be foremost on the differential diagnosis of such a patient, most especially with her very recent history of unexplained post partum infection with the *positive* blood culture, the clinical impression was "joint effusion" and flare of RA. Maria was given an iv Toradol injection and oral Vicodin for pain with some improvement and discharged to follow up with orthopedics. I could not find any mention during this encounter of her recent infection, with positive blood culture only 11 days earlier—and this recent infection

had incomprehensibly been inadequately treated for only two days! Apparently Dr. Hyan Chung was the ED physician staffing this case responsible for supervising PA Aarstad. Maria was discharged on crutches with knee immobilization, sometime around 19:30 to 20:39, to take Motrin and Vicodin and follow up with orthopedics. From pages 26-28 of Dr. Chung's deposition, he cannot say whether he absolutely saw this patient (stating "vaguely I recall seeing her" in his deposition page 27, line 9) and this is 4 years later, and there were no notes, in fact, stating he did in the chart, and it would appear no official Spanish interpreter was used to translate. Furthermore, in his deposition on page 44, lines 12-13, he stated that he was not aware that Maria had an incompletely treated serious infection, only 11 days earlier at the very same hospital, where records would have been readily available had anyone looked. On 07/26/10, clearly the communication between Dr. Chung and PA Aarstad was apparently superficial and virtual at best, and neither of them obtained anything resembling a meaningful history regarding their patient, Maria Quiridumbay. Neither of them performed a pelvic exam which was required.

On Wednesday, 7/28/10, Maria, with persisting multiple joint pains, returned again to Hudson Valley ED, arriving by EMS, at around 06:59 am, seen in Triage complaining of left knee and right hand pain. Her vital signs included Temp 97.8; Pulse-121; Resp 18; BP 92/59. Her initial evaluation by attending ED physician Sachin Shah, MD, revealed tachycardia of 121 along with borderline low blood pressure, and "+ swelling, tenderness and erythema of knees, hands". In fact, at 08:06 RN Theresa Ang, noted "left leg and right hand pain scale 10/10. Dilaudid 2 mgm ivp given". Only some 45 minutes or so earlier, at 07:17 am, nurse Ang, RN had given this patient 2 Percocet tabs, po, and 30mgm im Toradol, without much apparent relief since she now needed the iv Dilaudid. Of interest, the Peekskill Community Volunteer Ambulance EMS which transferred Maria to Hudson Valley Hospital ED recorded two sets of blood pressures and pulses during transfer in: 87/56 with pulse 136 and 92/60 with pulse 125. At the ED, her BP and pulse were initially 92/59 and 121. At discharge around 09:05 am, some two + hours after arrival, her BP was 93/49 with pulse 125. These were concerning borderline low blood pressures and very concerning elevated pulse rates in a 35 year old patient. Pulse rate along with WBC counts are amongst two of the four criteria suggesting a diagnosis of systemic inflammatory response syndrome (SIRS) in patients with possible sepsis and infection—and only two positives are required for that life-threatening diagnosis to be validly considered. Despite the preceding recent history and this presentation with unexplained pain, abnormal vital signs, and the recent series of unexplained high WBC with left shifts (readily available for review had the computer records been accessed or the medical records themselves, or phone calls made). Again, despite all of the above, again, no female pelvic examination was performed. Maria was discharged as "arthropathy". Dr. Shah's action discharging a 35 year old patient who came in by ambulance with very borderline to abnormal vital signs including a BP 92/59, respirations of 18, and pulse of 121, with a pulse of 125 at discharge, represents questionable medical practice. The vital signs are a safety net which when awry demand explanation: no explanation was apparent to Dr. Shah or the treating team at the Hudson ED, and thus, this was an unsafe unacceptable discharge.

Dr. Sachin Shah was deposed 07/31/2015, regarding his care of Maria Quiridumbay on 7/28/10. On page 16, lines 13 and 18, he responded that he had access to her previous multiple visits and her OB records and that he looked at her last visit on 7/26/10, 2 days earlier. If he did he would have been aware of the fact that she had a very elevated WBC of 21,800 with a dramatic left shift. However, he appeared to not be aware of that (page 24, line13). If he were aware of any

of her WBC since delivery 14 days earlier, in the setting of her repeatedly very high unexplained pulses he should have known she might have SIRS (which she did) along with sepsis. On page 18 line 6, Dr. Shah said he included septic arthritis in his differential diagnoses for this patient, but all he did was "treat her pain, and I reviewed her records" lines 14-15 and ruled out infection. However, as I clearly noted Maria had post partum fevers, very elevated WBCs with high Band counts, and positive + blood culture for bacteria but unfortunately received only two days of iv antibiotics, namely, inadequate treatment. Had Dr. Shah appropriately and thoroughly, reviewed the records he said he reviewed, he would have known that his patient had sepsis and SIRS and needed urgent admission along with antibiotic coverage and critical care with specialty consultations including infectious disease. He did not do any testing and spent too little time getting a history, reviewing the records and evaluating her. When he was asked about the prednisone she took for her rheumatoid arthritis, pages 21-22, he was only partially right: prolonged low dose prednisone could suppress her immune system to some degree and can also suppress her normal adrenal-pituitary axis adversely affecting her own ability to produce stress steroids like cortisone. Incorrectly on page 25, line 14, he stated he ruled out sepsis, whereas, that would be done with ancillary blood test and probable consultations with infectious disease none of which he did. In fact the remarked upon abnormally elevated pulses Maria had along with the previously recorded WBCs and her clinical picture pointed to the SIRS with sepsis, for which she ultimately was admitted to Westchester Medical Center Hospital only hours later after he inappropriately discharged her. Page 30-31 suggests the fact that Maria in fact had joint symptoms from discharge post partum, and Dr. Shah incorrectly assumed it was only very recent: the cause of her symptoms and findings was an incompletely inadequately diagnosed, persistent, untreated post partum bacteremia with sepsis. As noted in the deposition, a number of the pain medications Maria was prescribed by the Hudson Valley Hospital ED physicians could have antipyretic effects masking any fever, however, fever is not always present with sepsis or SIRS. In fact, some of the sickest patients with sepsis and SIRS can become hypothermic. On page 40, line 17, it is apparent Dr. Shah did not know blood culture had been done, and he did not know it had been positive for bacteria, but he did say on page 41, had he looked appropriately he could have found it. On page 43 of his deposition Dr. Shah was asked how much time he might have spent with this patient, and his responses suggest he spent between 11 to 16 minutes total with this patient: this patient came in by ambulance, had persistent worsening complaints, had a very elevated pulse repeatedly and un-explained, had very elevated unexplained WBC counts, and a positive blood culture.

Dr. Shah was asked in his deposition what his patient died from and he said on page 48, lines 3-4, "pulmonary embolism". This he stated on page 48, line 7, was from "the autopsy report". In fact, as I understand, *there was no autopsy performed*! In fact, what this patient died from was sepsis untreated, with multi-organ failure. Within 4 hours of Dr. Shah doing nothing for her but medicating for pain and discharging her, she returned to Westchester Medical Center Hospital ED and was immediately diagnosed as septic shock, with SIRS and multi-organ failure manifested by acute renal failure, coagulopathy manifested by deep venous thrombosis but *no* pulmonary embolism documented, anion gap metabolic acidosis, respiratory failure along with intravascular collapse.

Apparently after discharge from Hudson Valley Hospital Center ED, by Dr. Shah around 09:00 am, and back at home Maria was seen by nurse Sharon Lavery, RN, of the Dominican Sisters

Visiting Nurses. She found her at home diaphoretic, pulse 120 thready, very drowsy and slow to respond, and a poor historian possibly hypothermic and with some episodes of diarrhea and vomiting. She apparently recommended her to go to Westchester Medical Center.

Maria Quiridumbay was at WCMC ED around 14:00, or within less than 5 hours from having been discharged by Dr. Shah at Hudson Valley Hospital ED. She presented lethargic, tachycardic, diaphoretic with weak pulse and initial BP difficult to obtain but 54/44 on 4th attempt. She had a swollen firm left leg, apparently since three days. She was awake but in severe distress on exam. She had suffered painfully and unnecessarily for weeks. Her physical exam was positive for tachycardia, left lower extremity grossly swollen and generally tender including calf, left knee effusion, and a pelvic exam with + purulent vaginal drainage at the cervical os with mild right adnexal tenderness. Laboratory tests included BUN 27, creatinine 2.6, with lactic and respiratory acidosis. She was admitted to the ICU requiring intubation for airway, was difficult to establish iv access, and was immediately begun on broad spectrum antibiotic coverage for septic shock. Her initial diagnoses were septic shock, intravascular volume depletion, hypercoagulable state, acute renal failure, anion gap metabolic acidosis, and occlusive deep vein thrombosis in the right femoral and both popliteal veins. Her picture was entirely consistent with sepsis and SIRS, secondary to post partum bacterial endometritis incompletely treated with secondary generalized bacteremia and sepsis. Despite aggressive hydration and broad spectrum antibiotic coverage, she continued to deteriorate and had a cardiorespiratory arrest with CPR/ACLS around 05:30 am and could not be resuscitated and was pronounced dead at 05:44 am 07/29/10, some 15 hours after admission, < 20 hours from discharge at Hudson Valley Hospital. Cause of death was cardiopulmonary arrest secondary to septic shock.

In summary, Maria Quiridumbay was a 35 year old Hispanic female who delivered her second child 7/13/10, who was septic at birth. Post partum Maria spiked three fevers and was found to have an elevated WBC with left shift, and blood culture was positive for Strep group A. She was treated as probable post partum endometritis for two days with iv antibiotics which for unknown inexplicable reasons were not continued beyond two days. She was discharged to home on 7/15/10, developed musculoskeletal complaints and swelling, continued to run very elevated WBC with left shift, and despite multiple visits to Hudson Valley Medical Center post partum, 7/26/10 and 7/28/10 with progressive musculoskeletal complaints felt to be "rheumatoid arthritis" did poorly deteriorating. Inexplicably, despite the clear known facts of her post partum incompletely treated infection, no connection was made between that and her unexplained complaints and failure to do well on the subsequent visits. Finally, too late, she was sent by visiting nurse services to WCMC ED where she was in septic shock with SIRS and multi-organ system failure and died 7/29/10.

The OB-GYN service and her treating doctors failed to meet the standards of care and contributed to her unnecessary death. After she was diagnosed as having probable post partum endometritis with + blood cultures and very elevated WBC, she was treated with an inadequate incomplete course of antibiotics. Drs. Kar and Jordan, and the rest of the OB-GYN treating team, failed to perform a complete and appropriate history and appreciate its clinical significance. These same doctors and team failed to appreciate the full exam and finding and ancillary tests including the persistent elevated WBC with left shift and the positive blood culture

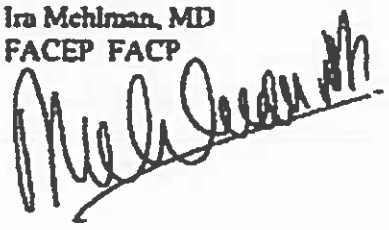
and the clinical significance of this. The same doctors failed to treat with appropriate antibiotics for appropriate length of time, thus, inadequately treating this patient. Had they continued correct antibiotics for appropriate time, patient Maria would have done well. They discharged Maria prematurely and incompletely treated her, deviating from standards of care, causing her harm and ultimately her unnecessary painful death.

Dr. Chung and PA Aarstad and their team of healthcare providers failed to meet the standards of medical care in evaluating and treating her and caused her harm contributing to her death. Both of them and their team were at Hudson Valley Hospital ED, and had ready access to the physicians, medical records, ancillary lab test performed, and had ample information and opportunity to access her history and records to prevent her unnecessary death. They deviated from standards of medical care, contributing to her unnecessary death. They failed to take an appropriate and complete history and appreciate its clinical significance, they failed to perform a complete and appropriate exam and to appreciate its clinical significance, they failed to review the readily available records, lab results including WBCs and the + blood culture, and they failed to appreciate the clinical significance of these materials, thus, inappropriately discharging patient Maria, untreated, leading to further deterioration and ultimately contributing to her unnecessary entirely preventable painful death. She needed to be admitted, the records and lab reviewed, and be started on a complete course of appropriate antibiotic and consultations with infectious disease consultants obtained and she would have survived. Furthermore, Dr. Chung did not meet the standard of care in his supervision of PA Aarsted. His supervision of the PA was virtual and inadequate, and more likely than not, he did not appropriately evaluate Maria. Furthermore, Maria Quiridumbay was incorrectly inappropriately triaged to "Fastrack" at the Hudson Valley Hospital Center ED on 7/26/10, when in fact she was most probably the sickest patient in that ED when she arrived and should have been seen and treated in the main critical care area by the best physician available, not by a PA, for the most part unsupervised. This was a failure of the Hudson Hospital and its ED triage system and of its "team" caring for Maria.

Sachin Shah, MD, did not meet the standard of care. He failed to appreciate the medical history, he did not perform an appropriate and complete review of the readily available medical records of Maria, he did not perform an appropriate and thorough physical exam to appreciate her condition, and he ordered no further testing and he inappropriately did not admit patient Maria, obtain appropriate consultation and treat her for probable early sepsis with SIRS. He failed to appreciate the clinical significance of her history, failed to appreciate the clinical importance of her laboratory WBCs and + blood culture incompletely treated, and incorrectly discharged her home, missing the last opportunity to admit her timely and initiate emergency treatment to save her. When Maria was evaluated and seen by Dr. Shah he was required to admit her and urgently initiate supportive care, appropriate aggressive hydration, and broad spectrum antibiotics. He failed to appreciate the clinical significance of the history, lab results, and Maria's clinical course. This denied her any chance of survival.

All of my above medical opinions are held to a reasonable degree of medical certainty and probability. I reserve the right to add to or amend my above opinions should additional material become available.

Ira Mehlman, MD
FACEP FACP



IRA MEHLMAN, M.D., FACP, FACEP

EDUCATION:

CORNELL MEDICAL COLLEGE MD Degree	NYC, NY June 1968
PRINCETON UNIVERSITY BS Degree in Physics and Molecular Biology	PRINCETON, NJ June 1963
Internship and Internal Medicine Residency	S.F., CA 1968-1970
Internal Medicine Residency/Endocrinology Fellowship Walter Reed Army Medical Center, Washington, DC	1974-1979

SOCIETIES:

Fellow of the American College of Physicians	(FACP)
Fellow of the American College of Emergency Physicians	(FACEP)
Board-Certified Internal Medicine	1977
Board-Certified Endocrinology/Metabolism	1979
Board-Certified Emergency Medicine	1991, 2001
Member, DC Academy of Medicine	Present

EXPERIENCE & APPOINTMENTS:

US Army Medical Corps, General Medical Officer, Europe	1970-1974
Chief, Emergency Medicine Department Washington, DC Walter Reed Army Medical Center (WRAMC)	1981-1992
Attending Staff, Internal Medicine, WRAMC	1979-1981
Assistant Professor of Medicine, USUHS	1981-1992
Associate Professor of Medicine, USUHS	1996-2001
Clinical Assistant Professor of Medicine, Georgetown University Medical Center	1980-1992

U.S. Congressional Escort Physician	1979-1992
Assistant Chief, Emergency Medicine Department, Sibley Memorial Hospital, Washington, DC	1992-1993
Senior Attending Staff, Emergency Department, Washington Hospital Center	1993-1994
Chief Physician, Internal Medicine, PsyCompCare, Silver Spring, MD	1992-1994
Director, Emergency Medicine/Acute Care Bethesda National Naval Medical Center	1994-1997
Director, Department of Emergency Medicine Greater Southeast Hospital, Washington, DC	01/98-06/98
Director, Department of Emergency Medicine Memorial Medical Center, South Amboy, NJ	11/98-08/99
Senior Attending Staff, Emergency Department Walter Reed Army Medical Center, Washington, DC	1998-2001
Director, Department of Emergency Medicine Saint Mary's Hospital, Leonardtown, MD	10/99-06/01
Director, Department of Emergency Medicine Mary Immaculate Hospital, Saint Vincent Catholic Medical Centers, New York, NY	06/01-11/03
Director, Department of Emergency Medicine Nyack Hospital, Nyack, New York	11/03-10/05
Associate Director, Department of Emergency Medicine Nyack Hospital, Nyack, New York	10/05 – 1/06
Senior Staff Attending, Department of Emergency Medicine Nyack Hospital, Nyack, New York	1/06 – 11/06
Staff Attending, Department of Emergency Medicine St. Joseph's Medical Center, Yonkers, New York	1/07 – present
Staff Attending, Department of Emergency Medicine North General Hospital, New York City, New York	2/07 – present

LICENSES: New York — current

LANGUAGES: Bilingual in French and English. Conversant in Spanish.

PERSONAL: U.S. Citizen. Born in New York City. Retired U.S. Army Medical Corps Colonel. Trained in Internal Medicine and Endocrinology. Traveled extensively with many congressional delegations as a physician to congressmen traveling throughout the world. Extensive experience in Emergency and Critical Care Medicine. Experience with HMO general medicine. Have practiced and taught in busy, high acuity emergency departments. Experience with problems and care of handicapped patients.